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Towards explanations for the findings of serious case reviews: understanding what happens in self-neglect work

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Introduction

The professional and inter-agency challenges of working with people who self-neglect have been exposed by a series of serious case reviews (SCRs) that have investigated often distressing and extreme circumstances. A study providing a consolidated analysis of 40 such reviews (Braye et al., 2015a; b) explored four interlocking domains within which these challenges are located: the individual, the team, the organisation and the inter-agency strategic body, the Local Safeguarding Adults Board (LSAB). It concluded that a further level of scrutiny was necessary in order to understand how feelings, values and beliefs, ethical tensions, and policy and practice ambiguities impact on individual practitioners and multi-agency systems.

The present paper draws its key purpose from that conclusion. It suggests that SCRs have neglected the wider systemic context when seeking to understand practice in a complex environment (ADCS, 2015). It employs analytic formulations drawn from both systems and psychodynamic approaches to cast light on the complex systemic processes embedded in self-neglect work. In particular, it uses Coordinated Management of Meaning (CMM) to hypothesise how public (political and social climates) and organisational (resource positions and service delivery configurations) contexts influence professional behaviour and relationships with people who self-neglect. In doing so, it builds on the need to interrogate the legal, ethical and organisational contexts within which people have to take decisions (Flynn et al., 2011). Such understanding is timely since, following the Care Act 2014, safeguarding adults reviews (SARs) must be commissioned in defined circumstances, including death arising from self-neglect.

First, though, in the continuing absence of a comprehensive national database, an updated set of findings is presented. This extends the core data set from the original 40 to 66 SCRs. As previously, this analyses themes arising from SCR conclusions and recommendations and focuses on what can be learned for effective work with self-neglect cases.

Locating self-neglect

In England, before Care Act 2014 implementation, self-neglect was excluded from adult safeguarding. This substantial sample of self-neglect SCRs therefore underscores the challenges such cases present. Their findings reinforce an emergent evidence-base of what works in self-neglect cases (Braye et al., 2011; 2013; 2014), incorporating:

- Ethical and legal literacy to navigate complex situations involving people's dignity and well-being, whether or not they have mental capacity;
- Relationship-building skills involving persistence, patience, expression of concerned curiosity and honesty, aimed at understanding self-neglect as part of this person's life journey;
- Sensitive and comprehensive assessment, including physical, psychosocial, environmental and social risk factors;

- Detailed mental capacity assessments that consider and routinely review the person's executive capacity – the ability to implement and manage the consequences of specific decisions – alongside their ability to weigh up information and communicate decisions;
- Interventions that are primarily negotiated but accompanied by imposed solutions where necessary, building on the person's own perception of their needs and situation;
- Multi-agency involvement, with the team around the adult bespoke to that person's needs and the type of self-neglect involved;
- Organisational arrangements that recognise that time-limited, care management, eligibility-driven workflow patterns will not provide the continuity and space required to work with adults who self-neglect;
- Supportive but questioning supervision.

Updating the evidence base

The Parliamentary and Health Services Ombudsman and the Local Government Ombudsman have jointly investigated self-neglect cases (PHSO and LGO, 2014; LGO and PHSO, 2014). In the former, self-neglect is not explicitly mentioned but is implicit in references to a house "in a terrible state", living conditions as "extremely poor, squalid" and a service user who said that he did not want any help. This case analysis contains some familiar themes in self-neglect cases, namely low levels of legal literacy amongst health and social care practitioners and inadequate mental capacity assessments. In the latter case, self-neglect is also implicit rather than explicitly referenced, emerging through references to the person's poor self-care and hygiene, inadequate diet, refusal to attend dental appointments and unkempt living conditions. The themes too are familiar, namely a failure to carry out a proper capacity assessment and community care assessment, to ensure regular visits and meaningful work by support workers, and to arrange appropriate supported living accommodation.

Self-neglect is also explicitly mentioned by the judge in Westminster City Council v Sykes [2014] although the case is principally useful as an excellent illustration of the careful balancing exercise that is needed in cases of risk involving lack of mental capacity and best interest decisions. The judgement refers to unhygienic and chaotic living conditions, refusal to accept personal care and poor medication compliance.

Since publication of the earlier papers, two SCRs have become available. The case numbers used extend the sequence adopted in the earlier study (Braye et al., 2015a).

Case number	LSAB, date, case name	Gender, age	Living situation	Circumstances
30	B Council, 2014, AA	Male, 82	Lived alone but family contact	Died at home in a fire
32	Waltham Forest, 2014, WD	Male, 74	Lived alone	Died at home

Case number	Published, nature of document,	Methodology	Self-neglect focus	Number of recommendations

	length			
30	Not published, executive summary, 26 pages	IMRs, chronology and SCR panel discussions	Central	12
32	Not published, serious case review, 108 pages	IMRs, four meetings of chosen senior agency members as review panel	Central	37

On-going searches and contacts with LSAB chairs and business managers have identified further cases where reviews have been completed. Information received also indicates that at least a further six SARs or learning reviews have been commissioned involving self-neglect. The same four-layered analysis will be used as previously (Braye et al., 2015a).

Layer one: case characteristics

Where known, cases are again equally divided between men and women but in this additional sample older people are more heavily represented. Where information is available about the cases updated or added to the database, seventeen featured lack of self-care and ten lack of care of one's environment. Fifteen cases also involved refusal of services and nine contained all three elements.

Case number	LSAB, date, case name	Gender, age	Living situation	Circumstances
41	Cornwall, 2014, L	Male, 81	Lived alone	Died at home
42	Cornwall, 2014, ND	Female, 72	Lived alone	Died at home, cause of death unknown
43	Coventry, 2013, Mrs D	Female, late 80s	Lived alone with family contact	Died in hospital
44	Hull, 2010, LD	Male, 54	Lived alone	Died at home
45	Essex, 2012, MM	Female, 89	Lived alone with support network	Died in hospital
46	Jersey, 2015, Mr Arthur	Male, 62/63	Lived alone	Died at home, unsubstantiated cause
47	Wakefield, 2014, Mrs A	Female, 71	Lived with daughters	Died in hospital of pneumonia and emphysema with bipolar disorder and self-neglect contributory factors
48	Wrexham, 2013, AR	Male, 54	Lived with his sister	Died in hospital of sepsis, pneumonia and pressure sores
49	Worcestershire,	Unknown	Unknown	Unknown

	2013			
50	Sheffield, 2014	Male, 70	Separated from his wife	Died at home, cause unclear
51	E Council, 2008, X	Mother, 75; son, 50	Mother moved to care home ; son rehoused	No energy supplies or state benefits; Mrs X treated for life-threatening infections
52	Camden, 2015, ZZ	Female, 79	Lived alone	Died in hospital, multiple organ failure due to septicaemia
53	Lancashire, 2014, Ms S	Female, 56	Unknown	Died
54	Mental Welfare Commission, Scotland, 2014	Male, 65	Lived alone	Died in hospital of cancer
55	Newham, 2013, LW	Female, 56	Lived alone	Died at home
56	Buckinghamshire, 2014, Mr Mrs H	Ages not given	Couple at home	Mr H died in hospital, Mrs H transferred to a care home
57	Buckinghamshire, 2015, J & K	Gender and ages not given	No details given	No details given
58	Norfolk and Suffolk, 2015, Mr AA	Male,42	Lived alone	Died in hospital, cardiac arrest and pneumonia
59	Suffolk, 2015, James	Male, 33	Supported living	Died in hospital after operation for distended abdomen
60	Glasgow, 2015, Mrs Ellen Ash	Female, 83	Lived with her son	Son convicted of wilful fire raising and culpable homicide
61	Devon, 2015, Mr AF (Father) and Mr AS (son)	Male, ages not given	Father and son living together	Rehoused separately
62	Hampshire, 2015, Ms B	Female, 46	Lived in residential care	Died in hospital, heart failure, obesity and depression
63	Knowsley, 2014, Adult A	Female, age not given	Lived alone	Hospital admissions & discharges
64	South Tyneside, 2015, A	Female, 84	Lived alone	Died in house fire
65	Sunderland, 2015, Angela, Barry &	Mother, 79; son, 56; daughter, 49	Family living together	Hospital admissions &

	Claire			discharges
66	Nottingham City, 2014-15, EW	Female, age not given	Lived alone	Died

Table 1: key characteristics of individuals who self-neglect

Layer two: key characteristics of the SCR

Self-neglect was a central feature in twenty cases, peripheral in five and implicit in one. Reviews use diverse approaches to learning, but some opaqueness remains regarding the identity of report authors and precise methodology followed. Case 41 adopts SCIE's systems methodology (Fish et al., 2009) whilst cases 32 and 46 appear to draw on elements of the significant incident learning process (Clawson and Kitson, 2013) without explicitly naming it. Once again, there is considerable variation in the length of the reports and the number of recommendations. To some degree this reflects the type of inquiry conducted.

As previously, not all are in the public domain, sometimes because of concerns that publication would distress the individual where they have survived and/or their family members. Nonetheless, this makes it difficult for the adult safeguarding policy and practice community to disseminate and implement effectively the learning that is available. The statutory guidance underpinning implementation of the Care Act 2014 (Department of Health, 2014) will not disturb this position as LSABs will only be obliged to report findings and recommendations of serious case reviews within their annual reports. If LSABs were required to implement a learning and improvement strategy, and if reviews were collated nationally, findings might have greater potential to inform practice and its management. This would complete the review process and also render more effective the provision (DH, 2014) that LSABs can commission SARs on good practice.

Case number	Published, nature of document, length	Methodology	Self-neglect focus	Number of recommendations
41	Published, overview report, 40 pages	SCIE systems approach	Central	6 findings, with 25 questions for the LSAB, and 8 items of "fringe learning."
42	Not published	Internal learning review	Central	None
43	Published, executive summary, 6 pages	IMRs and overview report writer	Peripheral	14
44	Published, overview report, 17 pages	IMRs, chronology, case records and interviews	Central	9
45	Published, case summary, 5 pages	Multi-agency serious incident review	Central	5
46	Published, serious case review, 23 pages	Action learning approach with two reviewers, a	Central	10

		learning and SCR panel discussion		
47	Not published	Internal learning review	Peripheral	Unknown
48	Not published	Unknown	Central (also neglect)	34
49	Not concluded and published	Unknown	Unknown	Unknown
50	Not published	Internal learning review	Central	7 agreed actions
51	Not published, 21 pages	IMRs, chronology, overview report	Central	8 to SAB and 8 to specified agencies
52	Published, serious case review, 61 pages	IMRs, chronology and SCR panel discussion	Central	8
53	Not published	Unknown	Central	Unknown
54	Published investigation, 30 pages	Case records, interviews and critical incident reviews	Central	17
55	Not published, 31 pages	Unknown	Central	10
56	Published executive summary, 12 pages	IMRs, chronology, review panel of agencies involved, overview writer	Central	11
57	Published overview report, 5 pages	Policy document review, case discussions, interviews	Unclear	5
58	Published, SAR, 53 pages	IMRs, chronology, family interviews, panel discussion	Central	14
59	Published, SCR, 53 pages	IMRs, chronology, overview report	Peripheral	14
60	Published, Significant Case Review, 34 pages	Systems based methodology, chronology, conversations with key staff	Peripheral	4 findings
61	Published executive summary, 4 pages	Single agency summary reports	Central	5
62	Published overview report, 38 pages	IMRs, chronology, panel discussions	Central	13
63	Published, executive summary, 9 pages	Chronology, examination of agency actions	Peripheral	13
64	Published,	IMRs, information	Central	19

	executive summary, 11 pages	from family member, overview author		
65	Published, executive summary, 31 pages	IMRs, review of themes, findings & key learning points	Central	9
66	Unpublished, learning review	Case discussion	Implicit	3 individual agency actions

Table 2: key characteristics of sample SCRs

Layer three: recommendations

Information regarding recommendations was available in twenty-five SCRs in this updated database. Two reviews did not contain any recommendations. Three reports addressed all their recommendations to unspecified agencies, presumably all those engaged in that safeguarding partnership. Three reports directed all their recommendations to the LSAB (Adult Protection Committee in Scotland in case 60), which was charged with developing plans that monitored how individual agencies were taking forward the learning into service development and improvement. Five SCRs had detailed action plans available and such plans were referred to in several other instances.

Twenty SCRs addressed recommendations to the LSAB or equivalent bodies in Wales and Scotland. Eight reports addressed recommendations to General Practitioners and eleven to unspecified agencies. All agencies in a safeguarding partnership received recommendations in five reports, adult social care in fourteen and NHS providers in twelve. Housing providers were specified in seven reports and NHS commissioners in eight. Third sector social care agencies and national government departments were named three times, the police four times, whilst environmental health, public health, welfare benefit agencies, advocacy organisations, fire and rescue servicers and the Ambulance Service were named very occasionally.

Layer four: themes within the recommendations

In an earlier article (Braye et al., 2015a) the themes within the recommendations fell into four broad categories, namely procedures, best practice, staff training and support, and the SCR process itself. These categories are used again here for the additional SCRs that were available for analysis, with familiar issues re-emerging.

Within the theme of staff support, training for a diverse range of professionals emerged in twenty SCRs and supervision and support in thirteen, including access to specialist advice on, for instance, learning disability and severe mental distress. Under procedures, the development, dissemination and review of guidance, especially for adults at risk who have capacity, was mentioned in nineteen SCRs. Twenty SCRs referred to referrals, assessment and/or reviews of need and risk. Co-ordination of services, multi-agency discussion and working together drew eighteen mentions, whilst recording, information-sharing and clarity on professional roles and responsibilities, including escalation of concerns, emerged in fourteen reports. Five SCRs commented on the need to ensure adherence to

safeguarding procedures and/or stressed the importance of case reviews and audits. Five referred to public awareness-raising.

Within the best practice theme, methods of working with people who are hard to engage, including responses to missed appointments and situations of high risk, were referred to in nine reports. Best practice in mental capacity assessments, including exploring people's choices, was emphasised in twelve reviews. Accessing and using legal knowledge was emphasised in eight reports; health care at home and during hospital admission and discharge in ten. Person-centred, relationship-based approaches, including use of advocacy, emerged in six cases, contract compliance in three. Family involvement in assessment and reviews was mentioned in four reviews, use of restraint with people with challenging behaviours once.

The greatest difference between this selection of SCRs and the sample reviewed previously (Braye et al., 2015a) relates to the SCR process. This featured only minimally here, with just five SCRs referring to their future use in training and service improvement, three to the management of the process in terms of the involvement of professionals, especially General Practitioners, and two to the importance of creating and monitoring an action plan to ensure implementation in policy and practice of learning. One SCR recommended that the LSAB should require a partnership approach to managing risks arising from organisational change or service reduction.

Cross-case analysis

As before (Braye et al., 2015b) four domains are used here to explore in detail the themes that were apparent on reading the SCRs.

Domain A: the practice interface with the individual adult

Considerable attention is given to whether practice was person-centred. Some SCRs were able through analysis of information to identify a logical reason for service refusal, to which agencies had given insufficient attention at the time. Examples included death of a dominant and reclusive parent, social awkwardness, anxiety about the cost of services, theft of money and belongings by bogus council officials and/or family members, loss of a trusted care co-ordinator and avoidance of hospital admission because of poor care previously or agoraphobia. The failure to maintain engagement and to express concerned curiosity about refusal of help meant that these logical forces remained obscured. That said, in two cases, there were persistent efforts to engage by uniform services and/or hospital staff, with narratives beginning to emerge of people's sense of shame about their living conditions and fear. Research (Ash, 2013; Braye et al., 2014) has also identified that people can be immobilised by shame and fear of stigma and condemnation.

SCRs also criticise distortion of a person-centred approach where questioning based on concerned curiosity is avoided. They comment that:

- The right to refuse services was correctly respected but the individual's ability to give informed consent was compromised by fears about being taken away from home.

- Non-engagement was wrongly construed as an active and meaningful choice and did not prompt careful assessment or escalation, or on-going effective monitoring of need, or exploration of the ability to implement and manage the consequences of decisions.
- Primacy was given to capacity and the right to make irrational choices, leading to case closure but leaving the individual in a known and unsafe situation.
- Practitioners felt that they could not impose help but no agency engaged in skilful negotiation, exploration or on-going contact.
- Reasons for refusal were not explored or assessed, not helped by the absence of multi-agency meetings, representing a failure to engage in a person-centred way in the assessment of need and risk.
- Too much weight was given to what a mother and son said, with a lack of professional challenge, which resulted in the right to self-determination overriding the right to protection.

A core component of effective practice in self-neglect cases (Braye et al., 2014) is maintaining engagement. Thus, several SCRs approvingly note that practitioners should intervene positively when dealing with difficulties and challenges of working with adults who self-neglect who do not wish to engage. This should respect rights to choice but continue to explore the choices being made and the reasons for that, and to monitor risks and offer support as much as possible, with consideration of imposed interventions when risks cannot be kept within acceptable limits. Research too cautions against the unthinking promotion of independence and choice without adequate consideration of safeguarding (Scourfield, 2010; Fyson and Kitson, 2010; Preston-Shoot and Cornish, 2014). Other SCRs note that health and social care practitioners did not visit despite known risks to health and well-being, such as squalid living conditions or extreme hoarding. There were inadequate efforts to find a service option acceptable to the individual to minimise risk and cases were closed rather than reasons for self-neglect and potential sources of support explored. Contact was sometimes attempted by letter or telephone rather than face-to-face.

Assessment of capacity is a core component of this domain. Frequently SCRs criticise the absence of a mental capacity assessment and the presumption without evidence that individuals have capacity. This could result in the gravity of hoarding being underplayed or in acclimatisation to self-neglect without seeing gradual deterioration. Particularly difficult were situations involving alcohol abuse or cases where capacity was uncertain or transient. For example, ten SCRs found that consideration was not given to the negative impact of learning disability and/or physical and mental health deterioration on the potential for fluctuating or transient capacity. A safeguard here would be involvement of other professionals and referral to a Court but these options were not considered despite the seriousness of the identified risks. Assessments of mental capacity and of risk thus lacked formality and rigour.

Scourfield (2010) questions the assumption of lifestyle choice and whether an individual took a deliberate and conscious decision to live in a particular way. What do individuals think of the various risks in their particular circumstances, including bed sores and unhygienic living conditions? One SCR in this sample interrogates the notion of lifestyle choice robustly; another observes that lying in a wet bed with skin deterioration should have triggered further assessments of capacity and risk; a third implicitly refers to executive capacity in noting that refusal of beneficial interventions did not

prompt assessment of capacity and the individual's ability to explain the different consequences of his choices; a fourth similarly finds that supporting choices about lifestyle was not accompanied by assessment of capacity to make balanced judgements or help to promote independent living. Not only, then, should capacity assessments include observation of basic living skills, inquiring into executive capacity, especially in situations where someone may have disabilities and/or has previously lived with reclusive parents, but equally assessment of capacity should be systematic and include detailed questioning of the assumption of lifestyle choice. Practice should consider explicitly the balance to be struck between autonomy and duty of care.

Less prominent in this sample of SCRs is consideration of carers although three reports comment that family members did not feel listened to. Four reviews conclude that the dynamics between the adult at risk and a family carer do not appear to have been fully explored. In another there was liaison with the family but their concerns were not acted upon.

Domain B: the professional team around the adult

Two themes dominate this domain. The first is assessment, planning, monitoring and review. Observations here might be general, namely that self-neglect cases are complex and staff may feel disempowered by the constant refusal of help in a context where options are perceived to be limited. They may be disinclined to visit and yet feel very responsible for case outcomes. They may be unclear how to respond when a self-neglecting adult refuses to give consent for a referral. Findings, however, may also be quite specific. Several SCRs refer to inadequate hospital discharge planning, with care at home not arranged or the condition of the house not addressed. Telephone referrals may not be followed up in writing, or chased subsequently, with the result that an individual becomes lost in the system. The risks involved in particular decisions, such as lying without interruption on a sofa and refusing basic care, are neither raised nor explored. There are other examples too of inadequate assessments of need, capacity and risk, sometimes complicated by substance misuse or by preoccupation with thresholds or by differing views amongst the professionals involved regarding presumption of capacity and self-determination. One SCR records specifically a culture of over-optimism that led to failure to meaningfully assess risk.

The second is inter-agency communication and collaboration. This might refer specifically to the difficulty of working at an interface, for example between mental health and substance misuse, or more generally to how work between agencies was uncoordinated. Referrals might lack significant detailed information, for example about hoarding levels, and thus be unclear about degrees of risk, or a professional with detailed knowledge might fail to initiate a multi-agency discussion, for example about whether an individual has capacity to take a particular decision. As a result, risks might be known about a situation but the individual remains at serious risk because the case is not explored in detail.

Once again, the level of legal literacy emerges as a concern amongst professionals working with adults who self-neglect. Case 60 concludes that legislative options should have been robustly considered but also notes the impact of the complexity of the legal rules on decision-making. Some SCRs stress how the Mental Capacity Act 2005 has been misapplied or how practitioners lack confidence in using its provisions. The Act is also occasionally criticised for being unclear about the

point at which a mandate to intervene exists when someone is gradually deteriorating. Other legal mandates, for example within housing legislation, were not considered in some cases of adults living in squalor or with serious hoarding. In one instance, for example, an individual was discharged home from hospital despite the seriously neglected condition of his house, without consideration of legal options. In this case, and elsewhere, SCRs are critical of professionals for failing to consider principles within a duty of care, although it is rare for reports to comment explicitly on the challenge of finding in each unique case the right balance between the right to private and family life and the duty of care to protect the welfare of an adult at risk.

Concern emerges also about levels of safeguarding literacy. Some SCRs conclude that professionals are unaware of guidance on self-neglect and also confused about what procedures to follow. This is sometimes explicitly linked to criticism of a lack of training. Also featured here is failure to escalate concerns or to raise alerts, with one SCR illustrating how practitioners with similar backgrounds did or did not refer to adult social care and adult safeguarding in the same situation. Thus, opportunities to raise safeguarding alerts were missed.

Less featured in this sample but noticeable as a recurring theme across SCRs is criticism of information-sharing, at the point of referral and subsequently, with decisions made on the basis of an incomplete picture. Similarly, when mentioned, recording is criticised as poor, for example not capturing the outcomes of interventions.

Domain C: the organisations around the professional team

The dominant emphasis in this domain amongst this sample of reports is on organisational policies. The SCRs comment on the absence of guidance and a proper process for managing self-neglect cases. One SCR comments, for example, on the lack of integrated systems, with agencies focused on delivering their service in relative isolation from other organisations. The application of thresholds has meant that adults with dual diagnosis (learning disability and mental health or substance misuse and mental health) have become no-one's responsibility. Thresholds may also appear confusing for staff and possibly lead to minimisation of risk or organisational apathy.

Less frequent are references to organisational culture and staffing although occasionally SCRs have referred to staff shortages, workloads, insufficiently challenging supervision and lack of resources impacting on decision-making and the management of long-term cases. The importance of supervision surfaces again in order to assist practitioners to question their approach and to retain perspective. One SCR, for example, refers to an apparent rule of optimism and the need to support staff to identify risks more effectively.

Domain D: the LSAB around the organisations and the exercise of interagency governance

In this further sample of reports, this domain features less prominently. Considerable faith is placed in training for a variety of professionals in mental health and mental capacity awareness, risk assessment and management, and adult safeguarding. Sometimes training in self-neglect, including the causes of hoarding, is emphasised, and occasionally coupled with a recommendation that commissioning and subsequent contract monitoring should audit outcomes of continuing

professional development initiatives. However, training will only prove effective where, alongside individual knowledge and skill development, organisations provide support for the implementation of learning and workplace cultures change to reflect messages from training and research (RiPfA, 2012; Braye et al., 2013).

There are occasional references to the difficulties experienced in commissioning and completing reviews. One SCR comments that the review panel lacked experienced in establishing terms of reference and, with the benefit of hindsight, might have involved a greater number of agencies. This review also concluded that it had over-relied on recorded information and could have interviewed a greater number of professionals involved in the case. This might have helped to understand some of the finer detail of decision-making. Another SCR reflected similarly, that the root cause of contributory factors had not been identified, with the resulting action plan being rather generalised. Elsewhere, the standard of individual agency management reports (IMRs) was variable, especially again in teasing out why decisions had (not) been taken. Occasionally, professionals such as General Practitioners had refused to release records, an occurrence which the new power in the Care Act 2014 for LSABs to request information may help to overcome.

SCRs comment on the absence of policies and protocols for managing multi-agency working when supporting adults at risk of self-neglect, especially those who have capacity and take decisions that impact on their health and well-being, or those where there is a gradual slide into self-neglect. Some policies are criticised for being poorly written or for not defining what is meant by self-neglect and when it becomes a safeguarding concern. Policies and protocols need to give direction, for example when there is a clear interface between learning disability and housing issues, or between mental distress and substance misuse.

Searching for explanations

Before the Care Act 2014 LSABs had no statutory obligation to conduct and publish SCRs. Now SARs are obligatory when adults die from, or have experienced serious abuse or neglect, and concern exists about how agencies worked together. SARs may also be commissioned in other circumstances. LSAB members must co-operate with such reviews and comply with requests for information. There is, however, no external scrutiny of LSABs when deciding whether circumstances require the commissioning of a SAR or what to include in its terms of reference, although such decision-making might be amenable to application for judicial review or investigation by the Local Government Ombudsman.

The methodology used should be determined by case circumstances (DH, 2014). Hitherto SCRs have mainly described what occurred, often uncovering departures from best practice but without answering the question of why practice unfolded as it did. The focus has been on the conduct of individuals and teams. Statutory guidance (DH, 2014) encourages this approach by requiring that SARs should determine what individuals and agencies might have done differently to prevent harm or death so that lessons learned can be applied to future cases. Nonetheless, the findings and recommendations have become repetitive. Arguably the reviews have been somewhat myopic regarding the context, or wider systems and structures, in which the events described, occurred. Little learning is therefore available at a macro level focusing, for example, on poverty,

organisational culture and the impact on staff and services of financial austerity. This critique has been applied to SCRs commissioned and published by Local Safeguarding Children Boards (Munro, 2011; Brandon et al., 2012) and by LSABs (Flynn et al., 2011; Ash, 2013). Indeed, statutory guidance (DH, 2014) requires sound analysis of what happened and why, concluding with recommendations for action to prevent reoccurrence. Arguably, practitioners and managers act in a political and social context wider than themselves and their agencies, which should be understood.

The purpose here, therefore, is to critically explore the underlying assumptions or orientations that practitioners and managers might bring to working with cases of self-neglect, and the impact of prevailing social, political, ethical and organisational contexts, in order to find new ways of understanding the tensions, dilemmas and outcomes involved, and further necessary learning for service improvement. This responds to another statutory purpose for SARs (DH, 2014), which is to promote continuous learning and improvement across organisations, but also extends the focus beyond just those individuals and organisations involved in a particular case. Various analytical formulations are considered, which might illuminate individual and organisational behaviours in self-neglect work, effectively interrogating the systems within which practitioners and managers work and seeking to understand how individuals, organisations and the wider local and national contexts influence each other. Put another way, how and why do routines of thought and action take hold (Fish et al., 2009)?

Hints of the learning from such a critical analysis are contained in practitioners' narratives about the feelings of anxiety and isolation that self-neglect work generates, the difficulty of stepping outside given organisational ways of working, and the challenges of working within the legislative and policy context (Braye et al., 2014). Inquiries by Coroners and the Ombudsman have pointed out both inadequacies and contradictions in the legal rules (Braye et al., 2015b). Researchers have commented on the powerful ethical force of the statutory presumption of capacity, with practitioners consequently reluctant to question people's choices and uncertain how to balance the protection of a capacitated adult with individual autonomy (Flynn, 2007; Galpin, 2010; Keywood, 2010). The different interpretations possible of such key concepts as autonomy and duty of care can prompt disagreements amongst policy-makers, managers and practitioners as to the appropriateness of particular adult safeguarding interventions (Preston-Shoot and Cornish, 2014).

Guidance for conducting SARs (SCIE, 2015) suggests that the task is to understand what causes a failure to work effectively. This requires not just a focus on individual staff but also consideration of organisational environment, culture and ways of working that affect and provide the context for individual decisions and actions. In other words, a twin-track approach to effective use of learning from SARs is required, namely workforce development *and* workplace development (Braye et al., 2013). The guidance then outlines different models for approaching the task, such as root cause analysis and the organisational accident causation model. However, whilst this focus on context helps to explore why a particular multi-agency safeguarding system behaved as it did, any subsequent recommendations must take cognisance not just of local geography but also of national legislation and policy which may (not) provide clear directions for how safeguarding challenges are best navigated in cases of self-neglect.

Individual and organisational practice patterns

Practice is shaped by durable patterns of thinking. Whittington (1977) noted how service users' experiences and needs may be obscured by organisational rules, professional assumptions about choice and responsibility, or defensive practice. Practitioners may then prioritise particular orientations, for example advocating clients' rights or meeting their needs. Braye and Preston-Shoot (2007) have proposed four orientations: technical, which prioritises meeting legal requirements; moral, which prioritises the pursuit of ethical practice; procedural, which emphasises an employer's policies; and rights, which foregrounds human rights and social justice as the guiding principle for decision-making. Each orientation brings a different analytical lens to adult safeguarding. Whilst individual orientations are not automatically right or wrong, drawing on their different contributions might afford a more rounded view of a task.

Ash (2010; 2013) refers to cognitive masks that camouflage practice dilemmas. Instead of discussing the choices service users and organisations make, and the risks inherent in their decisions, positions on autonomy and lifestyle choice are adopted to manage the dissonance arising from public policy ambiguities, practice uncertainties, resource shortfalls and ethical complexities.

Senge (1990) writes similarly of mental models that shape thought and limit action. He argues that problems occur when such mental models are tacit; existing below the level of awareness, remaining unexamined and unchallenged. One example (LGO and PHSO, 2014) is where a caring, well-motivated team, delivering generally a good standard of care, was "blinded" by a focus on independence. This resulted in the team supporting an individual's desire for independent living at the expense of considering his ability to manage in this environment. Hence, good practice management provides opportunities through meetings, supervision and case discussions to facilitate inquiry into different ways of looking at a situation and to challenge assumptions or orientations (Braye et al., 2014).

Discomfort about work can also generate defence mechanisms, specific strategies to reduce anxiety (Preston-Shoot and Agass, 1990). These may include:

- Withdrawal – little use of self, avoidance of proximity to the service user's problems or feelings;
- Directive authoritarianism – solutions prescribed before a situation is fully explored;
- Rigidity – alternative courses of action are not considered, expressed certainties remain unchallenged;
- Being liked – use of authority and the expression of challenge or concerned curiosity are avoided.

Implicitly published reviews reveal such mechanisms when commenting critically on case closures because service users have not engaged, on failures to inquire into reasons for service users refusing assistance, on assertions of mental capacity without rigorous assessments and on the use of letters to make appointments rather than personal attempts at contact. A particular ethical orientation can be seen when an SCR notes that non-engagement was wrongly construed as an active and meaningful choice, not prompting either exploration or assessment. The power of the concept of lifestyle choice emerges through several SCRs (for example, 32, 58, 59) that note how practitioners

do not question it, which leads to failure to see the gravity of the risks. Put another way, when empowerment and collaborative-based practice are the ethical positions of choice at the levels of personal professional identity and professional culture, this defines the acceptable relationship with service users (Pearce, 2007). Excluded then are alternative positions, involving perhaps concerned challenge or imposed interventions which might be relevant in the context of the case.

Thus, no decisions are context free. That context may render understandable apparently incredulous decisions. However, behaviour is influenced not just by individual motivations or orientations but also by levels of competence, professional identities, resources and policy ambiguities (Carson et al., 2015). Thus, explanatory frameworks need to capture how different levels of context interact.

Coordinated management of meaning (CMM)

CMM is a practical theory for understanding connections between interpersonal, organisational and public contexts and making sense of perplexing phenomena (Cronen et al., 2009; Pearce and Pearce, 2000). It aims to illuminate understanding of what is happening between participants, seeing work tasks as communication episodes, where these are events within a particular time frame, performed under a particular set of conditions. It also provides a framework for how, in this case, SCRs/SARs tell the story about the story, meaning that what is being co-constructed between people and contexts involved in an episode is a relational reflexive process. Those involved, including the report writer, are participants, not only helping others to understand the story but also participating themselves and influencing the review's co-construction (Pearce and Pearce, 2000).

SCRs are stories of cases but also should tell a story about the story (Lang, 1991). CMM offers a framework for exploring how practitioners and managers are affected by the many contexts in which they work. No decisions are context free. These contexts impact on each other and different contexts may be more or less dominant at particular times. Although arranged here hierarchically (Figure One), the different context levels are not fixed. All are potentially voices that influence how cases and options are perceived (Lang, 1991; Pearce, 2007; Cronen et al., 2009) and, exerting force both upwards and downwards, they shape and limit communication (Oliver, 2014). With this as the system in focus, a more contextualised and nuanced story can be told, linking cultural, legal, organisational, professional and relational dynamics (Oliver, 2014) as narrated by those involved.

Figure 1: levels of context

For SARs, these contexts may be translated into questions for reflective discussion. In key episodes how did different contexts influence practice? For example, how did social discourses about alcohol abuse in cases 15 and 32 (Braye et al., 2015a) influence organisational norms and practitioner roles and relationships? In cases 15 and 58, how did organisational resource availability impact on relationships with service users who were refusing to engage and demonstrating challenging behaviour? In cases 17 and 60, where reference is made to the complex legal framework on mental capacity and the tension between choice and safety, what was the impact on professional norms about autonomy and choice, and then relationships with service users and carers? What is the story here behind different agencies failing to explore legal options systematically and professionals presuming without question that service users had capacity? The outcome of such reflective discussions about how different contextual layers interact will suggest targets for intervention.

Those SCRs using an explicit systemic methodology come closest to identifying different levels of context although they do not explore how they interconnect and exert influence. Case 38 (Braye et al., 2015a) reports findings which, using CMM, are allocated to different levels of context and linked relationally, generating hypotheses for testing about how one contextual layer may have generated perceived obligations or prohibitions elsewhere, that is influencing some or all of the other levels of context:

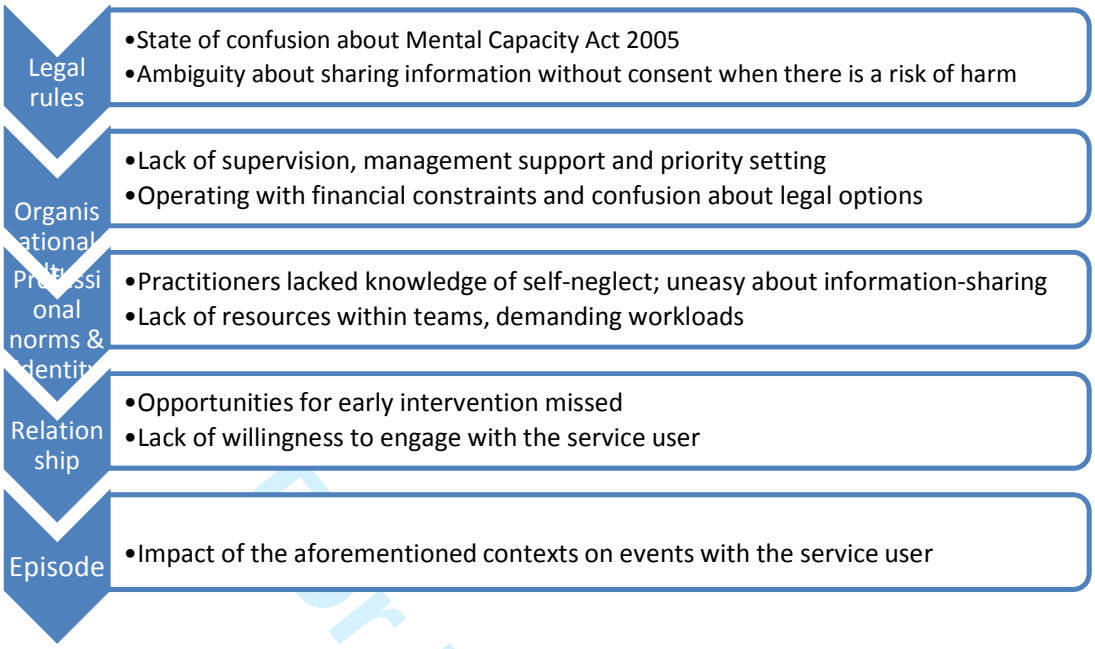

Figure 2: contextual influences on practice – case 38

Case 41 uses SCIE's systems methodology (Fish et al., 2009), which aims to explore why people responded as they did in the context of the systems in which they work, and to understand professional practice in context. The SCR highlights human biases, akin to the mental models and orientations mentioned above, interactions between professionals and the service user, responses to key practice episodes and management systems. Once again, however, the SCR does not explore them relationally but using CMM one can allocate SCR findings to different contextual layers and hypothesise about the impact of different contextual levels and build a story about the story.

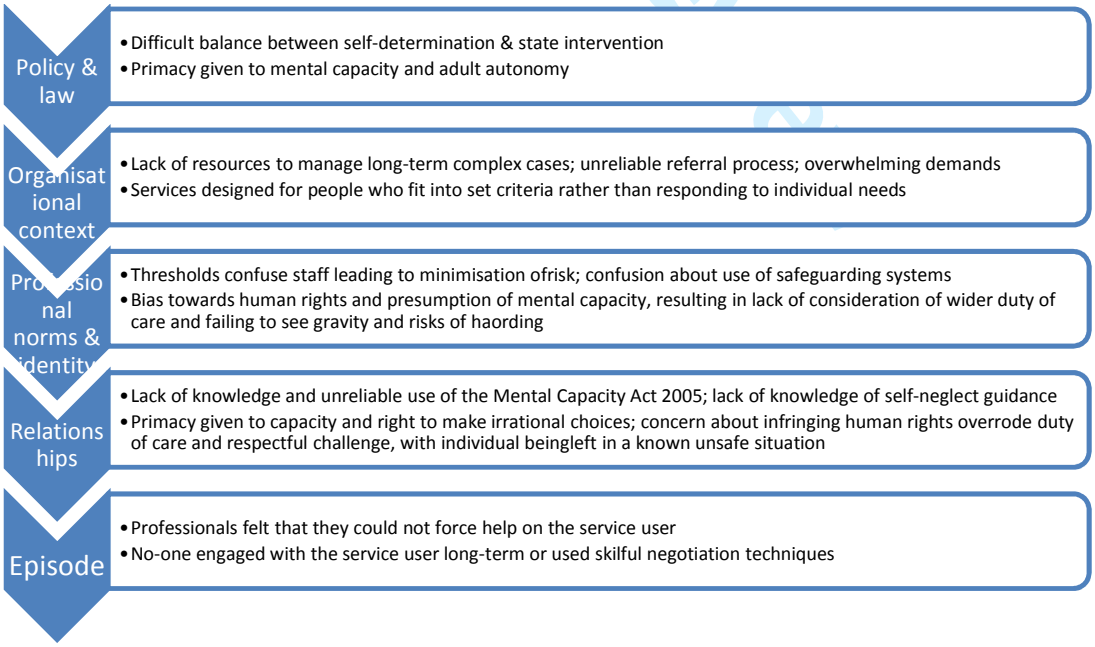

Figure 3: contextual influences on practice – case 41

Case 32 (Braye et al., 2015a) provides a searching and challenging analysis of adult safeguarding policy, mental capacity legislation, organisational cultures and professional behaviour. Although again the different contexts are treated separately, CMM allows the different contextual levels to be juxtaposed so that potential impacts can be hypothesised. Unusually this SCR refers to a *societal context*, noting a lack of consensus on how public services should reconcile proper respect for autonomy with a duty of care to step in when someone is clearly unable to care for themselves. The SCR also observes that responses to people with addictions are muddled, sometimes regarded as self-inflicted and meriting judgement, and sometimes seen as someone who has lost control and worthy of help. At a *policy and legal context*, the SCR is critical of the Mental Capacity Act 2005, especially in cases where adults slide gradually into self-neglect. Resolution of this lack of clarity about whether and when a mandate for intervention might exist is not helped, the SCR observes, by the six principles for adult safeguarding (DH, 2014), which juxtapose without comment of the potential tensions between them, empowerment and protection. CMM invites consideration of how these contexts shaped organisational norms and professional practice.

At the *organisational level*, the SCR notes that high thresholds were applied; there were muddled responses to people with addiction, and unclear routes for reporting and escalating concerns about high risk self-neglect cases. There was no training on relevant legislation for medical, social care and housing professionals or supervision on capacity assessments. Looking at professional culture, the same muddle about how to respond to people with addictions emerges, with some practitioners arguing that self-motivation was required before intervention could commence. The SCR questions the value of this approach when people's refusal to engage reflects their inability to act and bemoans the absence of outreach to those who lack capacity or resolve to self-refer. Alongside the difficulties of working at the interface of mental health and alcohol misuse, the SCR notes that work was not co-ordinated between agencies, referrals were unclear and information was not shared. It notes that professionals were concerned about being too heavy-handed but observes that the risks of not taking a sustained and targeted approach left this service user vulnerable and without sufficient support to sustain his dignity and well-being. CMM invites reflection on how this level was influenced by, and then impacted on other contexts.

At the level of *professional identity*, the SCR comments that adult social care staff, GPs and housing officers lacked knowledge of the law, which meant that potentially helpful legal options were not considered. They were also uncertain about the meaning of autonomy and assumed the service user to have capacity and to be exercising active and meaningful choices. Ultimately, this was not protective because it did not prompt careful assessment. Professionals saw his self-neglect as refusal to engage and as a lifestyle choice rather than as fear of engagement, for which he had good reason, and inability to act on what he knew. At the *relationship level*, then, non-engagement was seen as a trigger to withdraw rather than escalate concerns. The records portray him as uncooperative rather than vulnerable. His personal context was not understood. Had it been understood, his responses might have made greater sense to those who knew him. The SCR notes the power of the "autonomy driver" where professionals relied on an unfounded notion that this individual was making free and informed choices when his ability to manage his environment and personal care was severely compromised. It concludes by warning of the consequences of privileging an illusion of autonomy

over pragmatic humane intervention to secure people's well-being, dignity and right to life. However, on that argument consensus may not exist at societal, policy or professional levels.

CMM envisions safeguarding systems as transactions that involve emotion, meaning and behaviour carried and acted out by individuals and teams, shaped by narratives that are societal, organisational and professional (Oliver, 2014). Viewed this way, outcomes may be the result of logical forces (Pearce and Pearce, 2000), strongly experienced obligations to act in a particular way because of what is believed to be obligatory, prohibited or permitted. Thus, action may be responsive, *because of* a contextual feature or intentional, *in order to* create an outcome. In self-neglect work, there is often no categorically correct decision and both deciding to intervene or not can carry potentially adverse consequences. Social attitudes, reflected too in the views of different professionals, may demand action but also be concerned to protect autonomy. Legal rules both permit courts to intervene in the lives of adults *with* capacity but also foreground self-determination. Each SCR/SAR has to unravel how, in response to such practice uncertainties and public policy tensions, those in a case felt obliged, hesitant or constrained to act. Interestingly, the influence of practitioner feelings and emotions on relational interactions within teams and with service users often, however, remains a story untold as distinct from a story heard.

Some SCRs (for example, cases 2, 4 and 37 in Braye et al., 2015a) comment, therefore, on the importance of reflection, supervision and senior management support if the team around the adult at risk is to remain resilient and is not to become disempowered. Such opportunities may enable the team to establish a reflective pattern (Oliver, 2014) characterised by inquiry into the emotions and meaning generated by the case, and the impact of the policy, legal and professional cultures on how the team is performing. Similar recommendations have emerged from children's safeguarding SCRs. For example, Carmi and Ibbetson (2015) stress the importance of thinking time to consider the effectiveness of interventions and the exploration of narratives. Without such opportunities, individuals and teams may establish reactive or paradoxical rather than reflective patterns where their engagement with service users and other professionals is protective, defensive or ambivalent depending on the feelings generated by such cases and associated meanings or implications in relation to professional and personal identity.

Conclusion

This article's core purpose, in the light of repetitive findings, has been to explore what might lie behind such conclusions as an individual "failed by systems not in place or operated in isolation and in such a manner as to be ineffective" (case 35). To facilitate that exploration and provide the basis for theoretical analysis, the article has updated the database of SCRs involving cases of adults who self-neglect. The themes that emerge and the recommendations offered correspond closely with the evidence-base for effective work with adults who self-neglect (Braye et al., 2014), which includes a combination of negotiated and imposed interventions determined on the basis of skilled work with service users and detailed risk and capacity assessments, supported by legal and ethical literacy, challenging and supportive supervision and the involvement of senior managers.

The proposition is that SCRs, to be systemic and systematic, must engage with concerned curiosity with those involved in order to reflect on why they acted in the manner they did and how they

perceived the constituent elements of the adult safeguarding system in which they participated. Thus, to what degree has individual or collective practice been affected by contradictory societal expectations regarding autonomy and protection, or faultless performance in a human business? To what degree, again, has organisational culture impacted on a willingness to escalate concerns or to challenge? Is it just a loss of situational awareness that resulted in professionals acclimatising to levels of serious self-neglect rather than acting on evidence of declining capacity or have agency thresholds, supervision resources and national policy also impacted here?

A further proposition, then, is that SCRs must see micro practices through the lens of macro discourses since there too will reside contradictions, conundrums and incoherence (Oliver, 2014). The tension between mental capacity and a wider duty of care, and the ambiguity in what is meant by autonomy and lifestyle choice, are reflected at every level in the CMM model. The complexity of working within the balance and judgement of complying with the Mental Capacity Act 2005, responding to individual wishes but recognising that refusal to accept intervention is not an automatic right to be protected at all costs (case 41) requires actual and perceived alignment between different levels of context. If aligned, persistence in attempting to assess lifestyle risks and consideration of the duty of care to minimise risks, will accord with professional ethics and knowledge, be endorsed in the multi-agency network, supported organisationally and clearly endorsed by adult safeguarding legislation and policy, in a societal context that recognises the choices that sometimes have to be made between unpalatable alternatives.

One final observation is that SCR/SAR writers are not themselves immune from the ambiguities and uncertainties that permeate all the contextual levels that have been described here. Should something more have been done? To what degree should we tolerate individual choices, even when unwise? Should we adopt a protectionist position in the face of apparent autonomy-respecting professional networks? Is national adult safeguarding policy reflective of the evidence-base for working with adults who self-neglect? SCRs/SARs are part of the same systems as practitioners and managers into whose conduct they are inquiring. Their challenge, as explored in this article, is not just to illuminate practice in self-neglect cases but also to explore the stories being told about it.

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Appendix One

41	www.cornwall.gov.uk/the-reassurance-of-disengagement-2014
43	www.coventry.gov.uk/serious_case_review_mrs_d_executive_summary
44	Case 68 in A Decade of SCRs (2014) available from Hull Safeguarding Adults Partnership Board
45	www.essexsab.gov.uk/portals/26/MM
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60	www.glasgowadultprotection.org.uk
61	https://devoncc.sharepoint.com
62	www.hampshiresab.org.uk
63	www.knowsley.gov.uk
64	www.southtyneside.gov.uk
65	www.sunderland.gov.uk
Appendix One: Published source of SCRs	